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(1981:
Aug./Sept.)

Progress Through Partnership

Medicaid
Medicare
Management Institute

HEALTH CARE FINANCING ADMINISTRATION August/September 1981 Issue #5/6

MEDICAID MEDICARE EXCHANGE

PENNSYLVANIA BLUE SHIELD TO BE DC CARRIER

Pennsylvania Blue Shield was awarded a contract to replace Medical Services of DC effective October 1, 1981. Pennsylvania Blue Shield will be the Medicare Part B carrier responsible for processing claims and beneficiary inquiries for the District of Columbia and four surrounding counties in Maryland and Virginia. Pennsylvania Blue Shield's functions will also include making determinations and making payments of amounts due to physicians, providers, and beneficiaries on a reasonable cost or reasonable charge basis, as appropriate. The contractor will conduct reviews and fair hearings based on the actions taken, and will institute review procedures and screens to assure that services are medically necessary and consistent with acceptable practice.

Proposals to replace Medical Services of DC as a cost contractor under Section 1842 of the Social Security Act were also received from Maryland Blue Shield and Travelers Insurance Company. Contact: Al Wyman, 301-594-9498, FTS 934-9498.

ARKANSAS MEDICAID SERVICES CHANGED

Medicaid providers in Arkansas were recently notified of program reductions effective July 1, 1981. Changes were implemented because Arkansas' legislature reduced appropriations by $31 million of the original request.

The following changes were made: covered inpatient hospital services are based on average length of stay by diagnosis criteria; number of days payable per admission are based on the 50th percentile of the regional average according to the Southern Professional Activities Service; nonessential weekend admissions and excessive preoperation days are no longer covered; prior authorization is now required for tonsillectomy/adenoidectomy and for use of assistant surgeons; and there is no limit on number of admissions per year nor on total days covered. In addition, dental services for recipients over age 21 were eliminated, and physician and chiropractor services were reduced to 12 per year; covered prescription drugs were reduced from four to three per month. For further information, contact Carolyn Grant, Region VI, 214-767-6441, FTS 729-6441.

MEDICARE CONSULTATIVE ACTIVITIES

CARRIER REPRESENTATIVE GROUP (CRG) MEETING OF MAY 14, 1981

Dr. Carolyne K. Davis, HCFA Administrator, addressed CRG members for the first time during their May 14, 1981, meeting. While expressing optimism about the CRG/HCFA relationship within the consultative process, Dr. Davis recognized the significant budgetary problems that confront the carriers and HCFA. HCFA's overall objective is to provide for a quality health care system within these budgetary limitations.

The meeting focused on the budgetary impact on carrier operations, and included an agenda item dealing specifically with the FY 81 and 82 carrier budgets. As a result of budgetary reductions, a number of carrier activities will be reduced or eliminated. Among the carrier operations that will be modified or reduced are:

- Reduction of Computer Runs
- Systems Security
- Overpayment Tolerance
- Explanation of Medicare Benefits (EOMB)
- HCFA-1500 Health Insurance Claim Form
- Toll-Free Telephone Service

Since the CRG considered these proposed reductions insufficient, a meeting was held on May 19 to further reduce some carrier operations and to develop a proposed FY 82 contractor budget. Attendees included representatives of the CRG and Fiscal Intermediary Group (FIG), as well as HCFA central and regional office staff. The meeting resulted in the development of proposed revised Medicare contractor budgets for FY 82 and 83.

For further information, contact Paul Beller of the Medicaid/Medicare Management Institute, at 301-594-9455, FTS 934-9455.

All About Kickbacks & Rebates

Four Medicare kickback cases in 1977 and 1978 involved 31 persons and resulted in fines, restitutions, and imprisonments. In one case, physicians billed Medicaid/Medicare for services not rendered and received kickbacks from the medical laboratory handling their unnecessary tests. As a result, in June 1977, eleven physicians were fined over $30,000 and sentenced to a total of eight years' imprisonment. In another case, a nursing home pharmacy sent monthly kickback payments to the home in return for receiving the home's total prescription business. In June 1978, the pharmacist pleaded guilty to one count and was fined $1,000. The third case involved several officers of a Home Health Care agency who submitted inflated semi-annual cost reports to the Medicare carrier. Medicare funds were used to pay for vacations, non-existent attorney fees, treatment to non-Medicare patients, consultants, and kickbacks to physicians for referring patients. This agency was overpaid $273,000 in FY 75; three officers were convicted of mail fraud, conspiracy, and embezzlement in 1977 with a total of seven years' imprisonment and civil recovery procedures initiated. In the final case, a laboratory doubled its rates for services and procedures, and kickbacked a portion of the money recovered to various practitioners as incentives to utilize the laboratory. Nine of sixteen convictions to laboratory personnel and practitioners were imposed in 1978 with fines and restitutions over $150,000.

Kickbacks and rebates, two of the most common fraud activities, elevate the cost of services and supplies, and contribute to the spiraling costs of the Medicaid and Medicare programs. They also adversely impact on the ability of honest providers to participate in the health care industry.

An example of a kickback/rebate, as described by the Federal Bureau of Investigation, is where a laboratory "kicksback" or "rebates" to the physician ordering tests, a percentage of the Medicaid/Medicare reimbursement for those tests. In return, the physician agrees to refer all Medicaid/Medicare business to the laboratory. The physician receives payment in several ways; the laboratory either pays for the physician's office space or employees' salaries, or performs the physician's non-Medicaid/Medicare laboratory tests at no charge. These kickback/rebate arrangements may serve as an incentive for the doctor or other client to order unnecessary laboratory tests for Medicaid/Medicare patients. In addition, the laboratory charges to the Medicaid and Medicare programs are necessarily inflated to cover the costs of the kickbacks and rebates to those referring the patients. For those reasons, these activities are regarded by professional organizations as unethical, and are unlawful in most States.

Since 1972 Congress has provided some form of specific Federal penalties against those convicted of Medicaid and Medicare fraud and abuse. The current provision in sections 1877(b) and 1909(b) of the Social Security Act prohibit "solicitation, receipt, offering, or payment of any remuneration including any kickback, bribe, rebate for the referral, or for the procurement of goods or services for which a payment may be made by the Medicaid and Medicare programs." In 1977 Congress expanded this definition to include "any remuneration deferred, paid, solicited, or received directly or indirectly, overtly or covertly, in case or in kind . . . ."

continued on page 5

CHILD HEALTH CHECKUP

SUCCESSFUL CLOWNING AROUND IN NEW JERSEY

A clown performance about children's health checkups was so successful that New Jersey's Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program could not meet the demand for scheduling the performance. Bernice Cutler, EPSDT Field Service Coordinator, and Amanda Fuhro, Regional Staff Nurse, developed the skit to allay children's fears of doctors' offices with Bernice as the doctor and Amanda as Mandy, the patient. To meet the demand, New Jersey asked HCFA to help produce a videotape of the skit.

Dan O'Connor from HCFA's Office of Public Affairs (OPA) arranged for Amanda and Bernice to tape their performance at the Social Security Administration's audiovisual center.

In Mandy's Checkup, the doctor takes her anxious patient through each checkup procedure and keeps the audience of local children participating in the performance. The videotape runs 14 minutes and has been converted from videotape to 16mm film for distribution to New Jersey school systems by the State Museum Library.

In addition to copies for New Jersey, HCFA is sending one 3/4 inch videotape to each Regional EPSDT Coordinator for review by States. Requests for additional copies should be sent as soon as possible to Adrian Sybor, HCFA, OPA, so that production of copies can be arranged. Mr. Sybor can be reached at 301-594-9560, FTS 934-9560.

NEW MEXICO EPSDT COORDINATOR GETS CELEBRITY TO DO VIDEOTAPES

Ricardo Montalban is being heard on radio and TV stations throughout New Mexico explaining the benefits of preventive medicine in Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, thanks to the efforts of Carlos Fierro, State EPSDT Coordinator. Mr. Fierro saw Mr. Montalban on a public service announcement from the U.S. Department of Labor and asked him to tape some spots for EPSDT in New Mexico.

It took seven months and numerous contacts before Mr. Fierro was able to talk to Mr. Montalban about the project. Mr. Fierro sent scripts in Spanish and English, then made phone calls early every morning until he got through to Mr. Montalban who agreed to do the tapes without charge.

Radio stations responded well to the tapes with "99 percent agreeing to run the spots 3 or 4 times a day," according to Mr. Fierro. In order to have the radio spots mixed with music and one hundred copies made, as well as produce TV spots, the EPSDT Coordinator contacted Dan O'Connor in HCFA's Office of Public Affairs about combining the radio spots with existing TV spots produced by a public television station in Alaska. These TV spots have outdoor scenes of children playing in winter and summer which resemble areas of New Mexico.

Mr. O'Connor combined the radio spot with the Alaska TV tape to produce a high quality film now being used frequently by all TV stations in New Mexico. Mr. Fierro is planning spots in a Pueblo Indian dialect for use by an Arizona station serving the Pueblos in New Mexico. Contact: Carlos Fierro, State EPSDT Coordinator, 505-827-2401.

TASK FORCE FOR REGULATORY REFORM

On February 17, 1981, President Reagan signed Executive Order 12291 directing executive agencies to reduce the number, scope, and burden of new regulations. Agencies must also eliminate existing regulations that are burdensome or unnecessary.

HCFA Administrator, Carolyne K. Davis, Ph.D., responded by establishing the HCFA Task Force for Regulatory Reform on March 10. The task force, chaired by HCFA's Deputy Administrator, Paul R. Willging, Ph.D., is responsible for: assessing the need for existing HCFA regulations; developing a work agenda for revising or deleting regulations; and, assuring that the work agenda is accomplished.

The task force's priorities are: rules that affect the Medicaid program; and, rules that govern the conditions of participation for Medicaid and Medicare providers, including the survey and certification process.

On May 13 the task force sent letters to over 300 professional associations, consumer groups, providers, single State agencies and contractors soliciting their comments on HCFA regulations which should be reviewed by the task force. For more information about the Task Force for Regulatory Reform, or to make a suggestion or comment concerning it, write to: Ms. Rozann Brazil, Staff Director, HCFA Task Force for Regulatory Reform, Room G-A-5 East Low Rise, 6325 Security Boulevard, Baltimore, MD 21207.

Kickbacks and Rebates - continued from page 3

A violation of these provisions constitutes a felony, with penalty of up to a $25,000 fine or imprisonment of up to 5 years, or both.

HCFA's Office of Program Validation (OPV) is responsible for initial review of fraud practices, and full review of abuse practices. OPV then refers these kickback/rebate situations to HCFA's Office of Investigations (OI) for full scale investigation and prosecution. The goal of both offices is to detect and investigate all aspects of fraud and abuse in the Medicaid and Medicare programs.

Persons with knowledge of any suspected kickback, rebate, or bribe arrangements that may affect the Medicaid and Medicare programs are encouraged to contact Don Nicholson, Director, Office of Program Validation, 6325 Security Boulevard, Room 204L East Low Rise Building, Baltimore, Maryland 21207.

ACTION TRANSMITTALS

These Action Transmittals have been issued by HCFA between May and July 1981.

AT-81-25 Title XIX, Social Security Act: Deeming of Income Between Spouses (Refer to 42 CFR Parts 435 and 436; HCFA-AT-81-04, February 1981; Federal Register, 46 FR 82254, effective December 15, 1980)

AT-81-26 Monthly Report of Physicians/Practitioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated or Where Effectuated Sanction was Withdrawn (Refer to Sections 506(f)(2), 1128(a), 1160, 1862(d), 1862(e), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

AT-81-27 Program Validation Reviews (Refer to Sections 1102 and 1902(a)(27) of the Social Security Act, and 42 CFR 431.107)

AT-81-28 Title XIX, Social Security Act: Completion of Sterilization Consent Form (Refer to 42 CFR 441.257 and 441.258 and Appendix)

AT-81-29 Monthly Report of Physicians/Practioners, Providers, and/or Other Suppliers of Health Care Services Suspended, Excluded, Terminated, Reinstated or Where Effectuated Sanction was Withdrawn (Refer to Sections 506(f)(2), 1128(a), 1160, 1862(d), 1862(e), 1866, 1902(a)(39), and 1903(i)(2) of the Social Security Act)

INFORMATION MEMORANDUMS

This is a listing of Information Memorandums that were published between May and July 1981.

IM-81-10 Technical Assistance to States Under Section 1903(r) of the Social Security Act (The Schweiker Amendment)

IM-81-11 Current Status of Action Transmittals and Information Memorandums

IM-81-12 Technical Assistance and Consultation Resource List (Replaces HCFA-IM-79-04 dated January 17, 1979)

New State Medicaid Manual

By Spring 1982, the new State Medicaid Manual (SMM) will completely replace the current Medical Assistance Manual (MAM). The SMM will be phased in one part at a time until the MAM has been completely replaced. The MAM contained seven parts compared to the SMM which will have 14 parts. The SMM will include regulations, policies, and procedures needed to administer the Medicaid program.

Information that has been transmitted in Action Transmittals (AT), Information Memorandums (IM), Field Staff Information and Instruction Series (FSIIS), and Policy Interpretation Questions (PIQ), will be incorporated into the SMM and will become obsolete as they are incorporated. After all parts of the new manual have been phased in, any remaining transmittals will be obsolete.

Once the above transmittals become obsolete, a new State Letter Series will be used to request information, transmit material that need not be retained, and announce upcoming conferences and training activities.

To increase or decrease the number of copies you require for any SMM part, contact:

Health Care Financing Administration
Printing and Publications Branch, OMB
D-3 Gwynn Oak Building
Baltimore, Maryland 21207

Editor's Note: The MMX currently lists recently published ATs and IMs, however, when ATs and IMs are no longer published, we will list current issuances of the State Letter Series.

LITIGATION IN BRIEF

MMX is pleased to introduce this new feature which will highlight some of the more significant and recent civil court cases affecting the Medicare and Medicaid programs. Litigation in Brief will apprise you of the latest judicial actions and their resolution as well as any developing trends. Call John Bader of HCFA's Civil Litigation Branch on 301-594-9708, FTS 934-9708, for further information about these cases and about other judicial developments concerning the Medicare and Medicaid programs.

Beneficiary Appeals Procedures Challenged

The Court of Appeals for the District of Columbia held in Gray Panthers that, given the Medicare program's current determination and notice procedures, it was unconstitutional to deny hearings to claimants whose claims presented controversies of less than $100. The court characterized our current initial notices as so inadequate that claimants who are refused the opportunity for oral contact with decision makers (e.g., via administrative hearings) must be viewed as being denied the chance to pursue their claims properly.

However, the court did not insist on providing such claimants formal hearings, but instead remanded the case to the District Court to work out an appropriate package of procedural improvements with the parties. Depending on the procedural changes ordered, HCFA will determine whether to seek an appeal of the Circuit Court's decision.

In another case the U.S. District Court for the Northern District of California in William McClure declared the Part B fair hearings process unconstitutional because of the potential for bias on the part of carrier-appointed hearing officers. The court stated that Part B beneficiaries' due process rights would be adequately protected only if final decision making authority were vested in an independent tribunal.

In accordance with its findings, the court directed that a claimant who receives an unfavorable carrier hearing officer decision is entitled to an entirely new hearing conducted by an Administrative Law Judge of the Social Security Administration. Because of its Constitutional implications, the government has appealed this decision directly to the U.S. Supreme Court.

The Supreme Court has also granted the government's application for a stay of the District Court's order pending appeal and is expected to consider this case on its Fall 1981 calendar.

continued on next page

Litigation in Brief - continued

Special Care Unit Reimbursement

In the first test on the issue at the appelate court level, the Court of Appeals for the Ninth Circuit has upheld the Medicare program's refusal to treat intermediate or subintensive care units as special care units according to program regulations. A higher level of reimbursement is available for special care units.

Glendale Adventist Medical Center had claimed that their definitive observation units qualified for special care unit status because they met the regulatory requirement that care be extraordinary and be furnished on a concentrated and continuous basis. The Court of Appeals, however, gave deference to HCFA's interpretation of its own regulation. The court held that it was reasonable for the Secretary to interpret the regulation to require that special care units provide a level of care similar to that rendered in units specifically identified in that regulation, i.e., "burn, coronary care, pulmonary care, trauma, and intensive care units." Meanwhile, HCFA has amended the regulation consistent with the decision in this case to reduce the potential for future litigation on this issue. For cost reporting periods beginning after September 1980, the amendment eliminates the "extraordinary, concentrated, and continuous" criteria and instead provides that sub-intensive or intermediate care units are not to be considered special care units.

Medicare's Largest Overpayment Settled

The largest overpayment in Medicare's history has recently been settled. The overpayment, which covers 11 years, was due largely to phantom expenses on contracts between the provider, Martin Place Hospital, and related organizations.

During the course of bankruptcy proceedings, HCFA opposed the provider's initial offer of $630,000 to compromise the government's claim of $6,424,503.99. After further negotiations, the provider offered to settle for a cash payment of 50 percent, or $3,212,252. HCFA's Administrator agreed to accept this amount since this is what the government could recover if the facility were to go out of business altogether because of a forced sale. After a further investigation of its own, the Department of Justice also agreed.

Easier Recovery From Bankrupt Providers

In a decision favorable to the government, the U.S. Bankruptcy Court for the Western District of Pennsylvania ruled that HCFA may recover the full Medicare debt from bankrupt providers with only minimal court involvement. The decision permits HCFA to recover debts through offset rather than through lengthy legal proceedings.

In 1966 Monsour Medical Center signed a Health Insurance Benefits Agreement and became a Medicare provider of services. The court held that this agreement is an "executory contract." Since the trustee did not terminate the agreement, certain rights and obligations continued to flow from it. Thus, the Secretary was entitled to withhold a portion of the provider's current payments to recoup 1978 and 1979 cost report overpayments, even though the provider had filed a voluntary petition for reorganization under Chapter 11 of the Bankruptcy Code. HCFA is exploring with the Office of the General Counsel the feasibility of applying this reasoning in proceedings under the jurisdiction of other bankruptcy courts.

MEDICAID/MEDICARE HOSPITAL DISCHARGE DATA SET

Since the Professional Standards Review Organization (PSRO) program began, individual PSROs have been collecting hospital discharge data on all Medicaid and Medicare patients. The data have been periodically submitted to HCFA's Health Standards and Quality Bureau (HSQB) and incorporated into an overall computerized data base.

The data elements include: date of birth; sex; race or ethnic groups; residence (ZIP code); hospital identification number (PSRO identifier for each hospital); admission date; discharge date; diagnoses (principal and other); procedures (principal and other); disposition of patient (discharge status); principal payment source; and total number of acute certified days used. HSQB then added the following data elements to the record: pre-operative length-of-stay; length-of-stay; age; and diagnostic resource group (DRG) code.

The following discharge information has been accumulated to date:

Year	Number of PSROs	Number of Discharges
1977	80	4,740,000
1978	160	6,845,000
1979	153	11,965,000
1980	165 (anticipated)	11.9 million (anticipated)
1981	168 (anticipated)	12.0 million (anticipated)

Hospital discharge data can be used for a variety of analyses, e.g., average length-of-stay (ALOS) data for an expanded list of DRGs and procedures, and ALOS trend data. Data can also be used to compare national and regional norms, and to identify areas of high and low utilization.

Descriptive studies can be conducted on geographical variations in hospital use for Medicaid and Medicare populations. Descriptive studies show hospital use by area and payment source, age, sex, race, and/or diagnostic category. Analytical studies can also be developed to relate hospital use to area demographic characteristics, medical system supply characteristics, and hospital mortality.

The system can provide various forms of data that are available to a multitude of users including State agencies, PSROs, and fiscal intermediaries. For more information about the system's content and/or usage, contact Dennis F. Siebert, Director, Office of Professional Standards Review Organizations, Dogwood East Building, First Floor, 1849 Gwynn Oak Avenue, Baltimore, Maryland 21207, (301) 594-9207, FTS 934-9207.

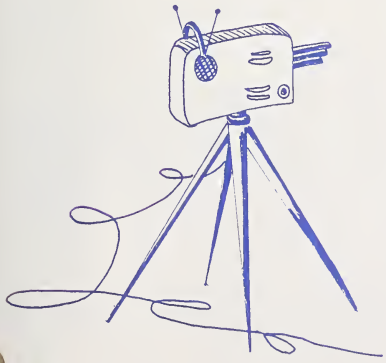
HCFA MEDICARE/MEDICAID HOSPICE DEMONSTRATION: COMMON INTERMEDIARY ROLE

HCFA's Bureau of Support Services, Office of Direct Reimbursement (ODR) may be serving as the Medicaid fiscal intermediary for 6 of the 14 States participating in HCFA's Medicare/Medicaid Hospice Demonstration. ODR is already serving as fiscal intermediary for both programs in Virginia and Colorado, two of the States participating in this demonstration.

The demonstration which began October 1, 1980, is being conducted by HCFA's Office of Research, Demonstrations and Statistics (ORDS), and is designed to evaluate all aspects of hospice care. It encompasses 26 sites in 16 States, and will run for a two year period with an additional six month wind down.

Since HCFA requested ODR to be the Medicare fiscal intermediary, ORDS recognized the benefits of ODR also serving as fiscal intermediary for the Medicaid portion of the demonstration because the accumulation of evaluation data on a common base would greatly assist the evaluation effort. ODR accepted this responsibility contingent upon the States adopting the reimbursement mechanism established for the Medicare portion of the demonstration. This unique arrangement will result in reduced costs of administration for the providers and States and should enhance the evaluation effort. Call Ed Norwood at 301-594-7503, FTS 934-7503, for additional information.

A NOTE FOR TRAINERS



Medicare/Medicaid, Which is Which?, has been distributed both in 3/4" videocassette and 16mm film to HCFA regional offices, Medicare contractors, and Medicaid State agencies. This presentation explains the basic differences and similarities between the two programs. It has been used with great success by and for HCFA's central and regional offices, and Social Security offices. There is a limited number of videocassettes and 16mm films still available for interested organizations not covered by initial distributions. To obtain copies of the film or tape, call Joseph Boston, M/MMI, 301-594-8648, FTS 934-8648.

HCFA HAPPENINGS

HCFA CENTRAL AND REGIONAL OFFICES MEET

The first regional conference since HCFA's regional functional reorganization was held in Baltimore July 14-16. HCFA's associate regional administrators for program operations and financial operations met with central office staff to familiarize themselves with new Medicaid and Medicare program responsibilities.

The conference's purpose was to establish a framework for constructive dialogue among the associate regional administrators within and between the regions, and between HCFA's central office and ten regional offices. The importance of good communication and coordination to facilitate achievement of common goals was stressed.

On July 15, Dr. Carolyne Davis, HCFA Administrator, described how the functional realignment of regional offices complements the 1979 central office reorganization. This new realignment will help HCFA share expertise of Medicaid and Medicare program areas, and will help to identify and resolve common problems. Dr. Davis expects the integration to reduce Federal intrusion and burden on State agencies, contractors, and beneficiaries. Finally, she believes the new realignment will better coordinate HCFA's efforts to manage the Medicaid and Medicare programs more efficiently and effectively.

Dr. Davis also described the outlook for HCFA's major initiatives: competition strategy, long term care, and hospice care.

HCFA'S REGION II EXPANDS TO PUERTO RICO

Anibal Sanchez has been appointed Acting Assistant Regional Administrator to head up the new HCFA Region II field office in Santurce, a section of San Juan, Puerto Rico.

The new field office will perform some functions previously administered by the New York office and will also put HCFA management in closer proximity to Medicaid and Medicare program operations in Puerto Rico and the Virgin Islands. The Santurce office, under the direct supervision of Regional Administrator, William Toby, will be better able to work with Medicare contractors, government health agencies, medical and other professional health organizations, and beneficiary and consumer groups.

The new office is located in the Caso Building, 1225 Ponce de Leon Avenue, Santurce, Puerto Rico 00907, telephone 809-753-4433.

HCFA'S NEW MAILING ADDRESS

As of July 1, 1981, all HCFA's central office mail should be addressed to:

6325 Security Boulevard
Baltimore, MD 21207

Please note this change!

HCFA ESTABLISHES FIVE ASSOCIATE ADMINISTRATOR POSITIONS

HCFA Administrator, Carolyne K. Davis, Ph.D., created five positions to simplify and reduce the number of senior staff reporting to her, and to improve the coordination of top HCFA management. Previously, 25 persons reported directly to Dr. Davis. This prevented her and the Deputy Administrator, Paul R. Willging, Ph.D., from concentrating on key issues and it also slowed down the decision making process in areas where bureaus and office directors need guidance.

The five new positions are:

Associate Administrator for Operations - responsible for HCFA central and regional office program operations, including contracting with States, and intermediaries and carriers for program administration.

Associate Administrator for Policy - responsible for all aspects of HCFA policy, planning and development.

Associate Administrator for Management and Support Services - liable for internal agency operations.

Director, Office of External Affairs - accountable for HCFA's relationship with beneficiaries, States, providers, and the general public.

Director, Office of Executive Operations - responsible for HCFA's decision making and communications processes.

As we went to press, the following appointments had been made: James F. Donovan, M.D., Associate Administrator for Management and Support Services; Charlene G. McCants, Associate Administrator for External Affairs; George A. Thompson, Associate Administrator for Operations; and Martin Kappert, Deputy Associate Administrator for Operations.

OMS MOVES

By the end of September, the Bureau of Program Operations' Office of Methods and Systems will have completed its move to the ground and second floors of the Meadows East Building. The majority of OMS' telephone numbers will not change. OMS has four divisions: Systems Review and Evaluation; Methods and Systems Requirements; Systems Planning and Development; and Eligibility Systems. OMS' new address is:

Health Care Financing Administration
Bureau of Program Operations
Office of Methods and Systems
300 Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

MMMI EVENTS

Fiscal Intermediary Group (FIG) Meeting
Late October — Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS 934-9455

State Medicaid Directors' Mid-Year Conference
December 3-4 — New Orleans, LA

Contact: Edward Palder
301-594-8940
FTS 934-8940

Carrier Representative Group (CRG) Meeting
January 14 — Baltimore, MD

Contact: Paul Beller
301-594-9455
FTS 934-9455

"Proposed 1982 National Surveillance and Utilization Review (S/UR) Conference"

Are you interested?
Would your State be represented?

Contact: Marlene Jones by November 1
301-594-8945
FTS 934-8945

READERS ARE ADVISED TO WATCH
THIS SPACE FOR UPDATED
SCHEDULES OF EVENTS

SEATTLE'S HARBORVIEW SENIORCARE PROGRAM (HSP)

Harborview Medical Center in Seattle, Washington, is the site for the Seniorcare program designed to eliminate gaps in the delivery of continuous, multidisciplinary care to the frail elderly living in the inner-city. Other objectives of the program are to address deficiencies in training health professionals on the appropriate health care for the elderly, and to expand the knowledge on distributing health related services to the elderly in an American urban setting.

Under design since 1976, the program will feature five levels of care when it becomes fully operational: inpatient, day hospital, ambulatory, long term institutional, and home based care. The program initially concentrated efforts on providing: multidisciplinary geriatric consultation to existing inpatient units; ambulatory care in a primary care clinic setting; nursing home followup service at three central Seattle long term care facilities; and home based care through three Puget Sound home health agencies.

The Seniorcare program is sponsored by a grant from the National Institute on Aging, and is supported by the Administration on Aging. Harborview Medical Center, a university hospital owned by the county, was selected for this program for several reasons. First, it has traditionally served the inner-city population. Second, it has strong community support. And third, it is a clinical teaching site for health professionals from the six schools of health sciences at the University of Washington. This last aspect is particularly relevant for HSP to accomplish its objectives since affiliation at the University of Washington hospital provides access not only for pre-doctoral and doctoral students of the health agencies during their education, but also to large facilities with research expertise in gerontology and health services.

Multidisciplinary case conferences are conducted on patients directly cared for, or consulted by the HSP team. The conferences feature a review of patient discipline problems by representatives from internal medicine, psychiatry, physical medicine and rehabilitation (including physical, occupational, and recreational therapy), social work, nursing, pharmacy, dentistry, and psychology. Students from the related professional schools attend conferences and assist in patient care under the tutelage of faculty preceptors.

HSP will also address clinical and health service research issues. Multidisciplinary assessment instruments and protocols are being developed to respond to individualized patient care and the appropriateness, completeness, and cost of services provided within this program. Access to data regarding those services and their costs (via a comprehensive University Hospitals record keeping system) will help in redressing knowledge deficiencies regarding the costs and outcomes of health care delivery to the elderly in this program.

The program at Harborview resembles University of Washington's psychiatrically oriented programs at the Seattle Veterans Administration Hospital and Tacoma

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REGULATION

Following are recent HCFA regulations of interest to Medicaid and Medicare program managers. Questions may be directed to the contact persons listed with each regulation.

Medicaid and Medicare Programs: Supplemental Security Income, Medicaid, and Social Security; Continuation of Benefits and Eligibility for Certain Severely Impaired Recipients Who Work - Correction Notice
04/15/81 Federal Register
Contact: For SSI - Fred Miranda, 301-594-7341, FTS 934-7341; For Medicaid - Richard Cody, 301-594-9050, FTS 934-9050; For Title XX - Mrs. Johnnie Brooks, 202-472-4415

Medicaid and Medicare Programs: National Professional Standards Review Council; Meeting - Notice
04/20/81 Federal Register
Contact: Cleo E. Hancock, Jr., 202-245-6097

Medicaid and Medicare Programs: Semi-Annual Agenda of Regulations (From Office of the Secretary) - Notice
04/30/81 Federal Register
Contact: Each regulation in the agenda includes a contact person for inquiries and comments.

Medicare Program: Technical Amendments on Reconsiderations and Appeals Under the Hospital Insurance Program - Correction of Final Regulation
05/01/81 Federal Register
Contact: Jack Wasserman, 301-594-9300, FTS 934-9300

Medicaid and Medicare Programs: Privacy Act of 1974; Report of New and Amended Routine Uses - Notice
05/01/81 Federal Register
Contact: Glenn J. Martin, 301-597-2999, FTS 987-2999

Medicaid and Medicare Programs: Validation of Accreditation Surveys of Hospitals - Correction on Final Rule
05/05/81 Federal Register
Contact: Margaret VanAmringe, 301-594-9712, FTS 934-9712

Medicaid and Medicare Programs: Privacy Act of 1974; Report of New System - Notice
05/15/81 Federal Register
Contact: Kathy Ellingson, 301-597-2305, FTS 987-2305

Medicare Program: Ambulatory Surgical Centers - Notice and Request for Comments
05/22/81 Federal Register
Contact: Bernard Truffer (Reimbursement), 301-597-1369, FTS 987-1369, Donald Young, M.D. (Coverage), 301-594-9690, FTS 934-9690

REVIEW

Medicaid and Medicare Programs: Pharmaceutical Reimbursement Board; Public Hearing on Maximum Allowable Cost Determinations, Cancellation - Notice of Cancellation of Public Hearing
06/11/81 Federal Register
Contact: Joel Schaer, 301-594-9777, FTS 934-9777

Medicare Program: Supplemental Health Insurance Panel; Meeting - Notice
06/18/81 Federal Register
Contact: Robert Silva, 301-594-9412, FTS 934-9412

Medicaid Program: Medicaid Management Information Systems Performance Standards - Notice with Comment Period
06/30/81 Federal Register
Contact: Newton Dikoff, 301-594-8190, FTS 934-8190

Medicare Program: Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs for Cost Reporting Periods Beginning on or after July 1, 1981 - Final Notice
06/30/81 Federal Register
Contact: Carl Slutter, 301-594-9344, FTS 934-9344

Medicare Program: Schedule of Limits on Home Health Agency Costs Per Visit - Final Notice
06/30/81 Federal Register
Contact: Carl Slutter, 301-594-9344, FTS 934-9344

Medicare Program: Economic Index for Physicians' Services for the Period July 1, 1981 through June 30, 1982 - Notice
06/30/81 Federal Register
Contact: Paul Riesel, 301-597-1843, FTS 987-1843, or Joseph Romano, 301-594-1023, FTS 934-1023

Medicaid and Medicare Programs: Periodic Review of Rules (Due date for data, information, and views is 09/15/81) - Notice
07/14/81 Federal Register
Contact: For HCFA Rules - Jodi Dunn, 301-594-7952, FTS 934-7952

Medicaid and Medicare Programs: Pharmaceutical Reimbursement Board; Final Maximum Allowable Cost (MAC) Determinations for Certain Drug Products (Effective date 08/28/81) - Final Notice
07/14/81 Federal Register
Contact: Charles Spalding, 301-594-5403, FTS 934-5403

Medicare Program: Statistical Standards for Evaluating Intermediary Performance During Fiscal Year 1981 - General Notice with Comment Period (Comments due 09/14/81)
07/15/81 Federal Register
Contact: Newton Dikoff, 301-594-8190, FTS 934-8190

Personnel

MEDICAID

Single State Agency Directors

Ray Scott - Arkansas Department of Human Services

Milton G. Klein - Idaho Department of Health and Welfare

MEDICARE

George Weinbaum - Director of Program Security, Blue Cross and Blue Shield of Greater New York

HCFA

Central Office

James Donovan, M.D. - Associate Administrator for Management and Support Services

Charlene McCants - Associate Administrator for External Affairs

George Thompson - Associate Administrator for Operations

Martin Kappert - Deputy Associate Administrator for Operations

Ralph Howard - Director, Bureau of Quality Control

Peter Bouxsein - Director, Bureau of Program Policy

Martin Duby - Director, Bureau of Support Services

Kevin Sexton - Director, Office of Management and Budget

James Scott - Director, Legislation and Congressional Affairs (he will also continue to be Director, Office of Intergovernmental Affairs)

Regional Offices

Robert O'Connor - Regional Administrator, Region IX, San Francisco, California

Phil Nathanson - Regional Administrator, Region V, Chicago, Illinois

George Holland - Regional Administrator, Region IV, Atlanta, Georgia

Anibal Sanchez - Acting Assistant Regional Administrator, Region II, New York, New York (field office is located in Santurce, Puerto Rico)

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Veterans Administration Hospital, and an outpatient program at the University of Washington Hospital. The goal of these programs is to expose all future physicians to the principles and practices of multidisciplinary, continuous care of the elderly as a required part of both undergraduate and graduate training programs at the University of Washington.

For further information about Harborview's Seniorcare Program, write to:

Dr. William R. Hazzard
Program Director
Division of Gerontology and
Geriatric Medicine
Harborview Medical Center
Seattle, Washington 98104

PROUD OF YOUR WORK?

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Trainers...Take Note!

Last September we suggested in "Trainers Take Note" that training departments consider producing their own videotapes. We explained that Virginia's Department of Welfare was doing this with great success. Because training dollars are even scarcer now, we'd like to share the experience of HCFA's Dallas regional office.

Background: Arkansas was faced with the need for State-wide training on Medicare and Medicaid. They wanted a training package that would explain Medicare and Medicaid, and would tell where to get additional program information. The Dallas regional office offered to produce a videotape to meet Arkansas' needs. The tape was to be used not only for Arkansas Hospital Auxiliary Association auxilians, one of the target audiences, but also for other audiences, for example, in-service training for hospital staff.

Process: The regional office team was well acquainted with the subject matter of the tape and had personally worked with beneficiaries, answering the same kinds of questions they wanted to address in the videotape. The team took two weeks to write and edit the script to ensure that the message was clear, precise and accurate -- one of the most important steps in producing a quality product. In addition, the staff pared the script to a bare 16 minutes to guarantee maximum viewer attention. They decided that the most realistic setting for the tape was a hospital room, so they used the regional office's public health unit. Actresses selected from the regional office staff rehearsed their roles as patient and auxilian answering basic questions about Medicare and Medicaid.

As production time drew near, the taping crew wisely consulted a video expert who advised them on how to produce a good tape. But, it was the HCFA team themselves who taped the program on that exciting morning. The team used basic audiovisual equipment, including a video camera, video recorder and playback machine, videotape, microphone, microphone mixer, television and a set of lights. This equipment is frequently available in State and Federal agencies.

The tape turned out very well, and both the regional office team and Arkansas were pleased. In fact, the American Hospital Association (AHA) featured the project at their national conference in Philadelphia on August 31. In that session, AHA members heard how hospitals in Arkansas have shown this tape to their patients on closed circuit TV, reaching up to potentially 1,000 patients a week in one hospital. The project saves both hospital staff time and money, not to mention the information it provides to beneficiaries.

If you would like to produce your own video program and conserve scarce training dollars and limited staff time, contact Mary Ace in HCFA's Region VI Dallas office, (214) 767-6401, FTS 729-6401. Both she and Jim McGroarty in Virginia, (804) 281-9050, will be happy to help you in whatever way they can.

If you would like to share your training experiences, or would like to discuss topics that are covered in this column, contact Susan Eberhard of M/MMI's Consultation and Training Branch at (301) 594-8655, FTS 934-8655.

Legislative Ledger

. On April 1, Secretary Schweiker discussed the Department's FY 82 budget request with the Senate Appropriations Subcommittee on Labor/HHS/Education. The next day he testified before the Senate Labor and Human Resources Committee about the administration's proposals for health and preventive service block grants, public health service hospitals, health planning, and health maintenance organizations (HMOs).

On April 7, Secretary Schweiker testified before the House Energy and Commerce Subcommittee on Oversite and Investigations on the administration's initiatives to curb the problems of fraud, abuse, and waste in health services programs.

. Carolyne K. Davis, Ph.D., HCFA's Administrator, appeared before the House Appropriations Subcommittee on Labor/HHS/Education on April 27 to discuss HCFA's $64.4 billion budget request for FY 82. She explained that by introducing a Medicaid cap on Federal reimbursement to States and phasing out the PSRO program, the administration hopes to reduce future expenditure increases below the 12.2 percent rise for FY 82. (HCFA's budget request for FY 82 is 12.2 percent higher than its FY 81 request.) Dr. Davis stated she would explore ways to curb inflation in health care delivery and help develop incentives that would promote deinstitutionalization. Other areas of discussion included Medicare contracting, MMIS and Medicaid quality control.

. The Senate Governmental Affairs' Permanent Subcommittee on Investigations held hearings on May 13 and 14 to discuss results of a study of unscrupulous home health agencies in Illinois, California, and Mississippi.

The topic of the May 13 hearing was the Chicago investigation and how the Medicare program can be defrauded by such dishonest operators. The next day, Paul R. Willging, Ph.D., HCFA Deputy Administrator, discussed HCFA's problems in administering Medicare and Medicaid home health benefits. Dr. Willging stated that HCFA currently has sufficient authority to handle fraud and abuse in HHAs with the exception of several reimbursement issues, such as costs of related organizations, agency management, and clerical costs.

. A hearing was held on June 5 with the House Energy and Commerce Subcommittee on Health and Environment concerning the Medicaid cost saving proposals as an alternative to a cap on Federal Medicaid funds and other program budget reductions. A number of panels disagreed with the administration's proposals because the poor, elderly, and disabled would be the hardest hit by budget cuts. However, The American Medical Association (AMA) supported the proposals which put a cap on Medicaid funds, and eliminate PSRO (Provider Standards Review Organization) utilization review. In addition, the AMA opposed repeal of the freedom of choice provisions which give States more flexibility in administering their programs.

For further information on these or other HCFA legislative issues, call Richard Chambers, HCFA's Legislative Reference Office, 202-426-3717.

CAPITALIZING STATE RESOURCES

M/MMI's Corrective Action Projects Division (CAPD) provides technical assistance and professional consultative services to State Medicaid agencies. CAPD focuses its efforts on resolving problems which significantly contribute to Medicaid quality control errors. Through CAPD, States are afforded the expertise needed to implement operational improvements in their programs in third party liability (TPL), data exchange, and error prone profiling/eligibility management. For additional information about CAPD and the services they offer, call Arthur Pergam, CAPD Director, (301) 594-8942, FTS 934-8942.

MEDICAID/CHILD SUPPORT PURSUE THIRD PARTY RECOVERIES

CAPD is developing a collection of information about cooperative activities between State Medicaid and Title IV-D agencies in the implementation of the new third party liability regulations. The regulations allow the Medicaid and Title IV-D agencies to enter into cooperative agreements to enforce the medical support liability of absent parents for their Medicaid eligible children. Many States have initiated pilot projects to demonstrate the feasibility and cost effectiveness of the Title IV-D agency's participation in gathering health insurance information from absent parents.

CAPD has information and supporting documentation about these joint Medicaid and Title IV-D activities in 15 States. While these projects all have the same goal of increasing third party recoveries, they have many different designs and results. If you would like information about other States Medicaid/Title IV-D activities, or would like to tell us about your own activities, call Jane Herlocker on (301) 594-9577, FTS 934-9577.

MASSACHUSETTS TPL

CAPD and Massachusetts' Medicaid staff have developed a manual post payment recovery procedure which focuses on maximizing State TPL recoveries for Medicaid recipients in long term care (LTC) facilities.

Medigap (Medicare supplementary coverage) is the most common type of insurance policy for Massachusetts' LTC population and typically covers skilled nursing care. This project was undertaken to study the potential for recovery from Medigap for LTC services and to implement a recovery system for future LTC claims.

The procedure includes identifying: LTC recipients with Medigap coverage; medical expenditures which may be recoverable; and, claims submitted to Medigap carriers. The cost benefit ratio to identify and pursue TPL in the sample population was estimated to be - $1 cost for $19 recoveries. Contact: Les Warren, (301) 594-9528, FTS 934-9528.

continued on next page

MARYLAND TITLE XIX/TITLE IV-D PROJECT

CAPD assisted Maryland Medicaid and Title IV-D agencies in an analysis of administrative costs to the Title IV-D agency in participating in a medical enforcement program. The cost analysis was needed for budget planning purposes and is also used for negotiating a cooperative agreement for collecting health insurance information from absent parents of Medicaid eligible children.

The analysis designated five functions that the Title IV-D agency could have in a future cooperative agreement. They included: conducting interviews; establishing medical support orders; verifying information; identifying medical insurance; and, notifying the Title XIX agency of employment changes.

Formulas were established to calculate the payment for Title IV-D staff to provide services within these functions. All costs were calculated on a prospective basis using the Title IV-D agency's projected caseload figures.

The analysis provided both agencies with a breakdown of the cost for each service that the Medicaid agency may be interested in purchasing from the Title IV-D agency. It also helps the Medicaid agency decide which services to purchase from child support staff if fiscal limitations restricted the selection.

The project team extensively researched Title IV-D field operations to determine how medical support and child support functions might be incorporated. This enabled the team to develop "model" flow charts describing the processes of establishing and enforcing medical support obligations, and detailing the interface between the Medicaid and child support agencies. The flow charts data and data drawn from the Title IV-D agency (staffing levels, salaries, caseload numbers, etc.) facilitated the development of the cost analysis.

Contact: Jane Herlocker, (301) 594-9577, FTS 934-9577.

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LOOKING FOR PERSONS WITH MEDICAID ELIGIBILITY EXPERTISE?

The Medicaid/Medicare Management Institute has published its first issue of the Technical Assistance and Consultation Resource List series. "Medicaid Eligibility Expertise" was distributed in August to all State agencies administering medical assistance programs.

"Medicaid Eligibility Expertise" lists State personnel with recognized expertise in Medicaid eligibility related to: administration and management; aid to families with dependent children; beneficiary entitlement; caseworker training; claims processing; corrective action planning; Federal interface; spend-down management; third party liability; and, quality control. Those listed are offering cross-State technical assistance and consultative services to other States. The list identifies other areas of expertise offered by each person and includes address and telephone number.

For a free copy of "Medicaid Eligibility Expertise," contact Patricia Alexander of the Medicaid/Medicare Management Institute, 301-594-9524, FTS 934-9524.

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